Texas Department of Insurance
Division of Workers' Compensation
Medical Fee Dispute Resolution, MS-48
7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1645
512-804-4000 telephone • 512-804-4811 fax • www.tdi.texas.gov

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name
First Street Hospital

Respondent Name
Liberty Insurance Corp

MFDR Tracking Number
M4-14-2340-01

Carrier's Austin Representative
Box Number 01

MFDR Date Received
March 31, 2014

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "I believe it would be fair and reasonable for Liberty Mutual Insurance to reimburse First Street Hospital for the actual acquisition cost of implant of $65,650.00, as shown on the invoice of L2 Surgical, LLC."

Amount in Dispute: $65,650.00

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "First Street Hospital submitted, as implant invoices, a bill from L2 Surgical LLC (page 8 of 18 of dispute). Payment was not allowed for the implant with this bill, as this is not the true manufacture's invoice as required by TDI rules. This billing statement is from the medical supplier/distributor and not the manufacture of the implants…. First Street Hospital billed and was denied for charges of $65,000.00 for three BioDFactor 0—5 ml Human Amnion Allograft and one Amniotic membrane allograft as the medical efficacy of this procedure has not been established. These amniotic products are considered investigational and are not presently considered as payable per CMS (Medicare). Also per Texas preauthorization, concurrent review, and voluntary certification rule 134.600, any investigational or experimental service or device for which there is early, developing scientific or clinical evidence demonstrating the potential efficacy of the treatment, service or device but that is not yet broadly accepted as the prevailing standard of care require a separate preauthorization. There was no separate preauthorization requested or given for these products or procedures. Liberty Mutual believes that First Street Hospital has been appropriately reimbursed for services rendered to (injured worker) for 09/19/2013 through 09/22/2013 date(s) of service. "

Response Submitted by: Liberty Mutual

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
September 19 – 22, 2013	Inpatient Hospital Surgical Services	$65,650.00	$65,650.00

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving a medical fee dispute.

2. 28 Texas Administrative Code §134.404 sets out the guidelines for reimbursement of hospital facility fees for inpatient services.
3. The services in dispute were reduced/denied by the respondent with the following reason codes:
   - X823 – Payment for charge is not recommended without an invoice or documentation of cost
   - X667 – the medical efficacy of this procedure has not been established.
   - 193 – Original payment decision is being maintained

Issues

1. Did the respondent support denial of service in dispute?
2. Which reimbursement calculation applies to the services in dispute?
3. What is the maximum allowable reimbursement for the services in dispute?
4. Is the requestor entitled to additional reimbursement for the disputed services?

Findings

1. The respondent raises two issues in their response (1) "Payment was not allowed for the implant with this bill, as this is not the true manufacture's invoice as required by TDI rules" and (2) "These amniotic products are considered investigational and are not presently considered as payable per CMS (Medicare) … require a separate preauthorization." 28 Texas Administrative Code §133.307(d)(2)(F) states in pertinent part, "The response shall address only those denial reasons presented to the requestor prior to the date the request for MFDR was filed with the division and the other party. Any new denial reasons or defenses raised shall not be considered in the review." Prior authorization was not raised prior to request for MFDR and will not be considered in this review. Review of applicable rules find;
   a. 28 Texas Administrative Code §134.404(g)(1) states in pertinent part, "A facility or surgical implant provider billing separately for an implantable shall include with the billing a certification that the amount billed represents the actual costs (net amount, exclusive of rebates and discounts) for the implantable. The certification shall include the following sentence: "I hereby certify under penalty of law that the following is the true and correct actual cost to the best of my knowledge." This information was included with submitted documentation. The respondent's position that the true manufacture's invoice is required is not supported.
   b. 28 Texas Administrative Code 134.403(d) states in pertinent part, "For coding, billing, reporting, and reimbursement of health care covered in this section, Texas workers' compensation system participants shall apply Medicare payment policies in effect on the date a service is provided…" Review of the CMS, Chapter 4, Section 200.4, "Billing for Amniotic Membrane" finds, "This section was added to show that hospitals should report HCPCS code V2790 (Amniotic membrane for surgical reconstruction, per procedure) to report amniotic membrane tissue when the tissue is used." There was no documentation to support that these products are investigational. The carrier's denial is not supported. The disputed service will be reviewed per applicable rules and fee guidelines.
2. 28 Texas Administrative Code §134.404(e) states that: "Except as provided in subsection (h) of this section, regardless of billed amount, reimbursement shall be:
   (1) the amount for the service that is included in a specific fee schedule set in a contract that complies with the requirements of Labor Code §413.011; or
   (2) if no contracted fee schedule exists that complies with Labor Code §413.011, the maximum allowable reimbursement (MAR) amount under subsection (f) of this section, including any applicable outlier payment amounts and reimbursement for implantables."

   No documentation was found to support the existence of a contractual agreement between the parties to this dispute; therefore the MAR can be established under §134.404(f).
3. §134.404(f) states that "The reimbursement calculation used for establishing the MAR shall be the Medicare facility specific amount, including outlier payment amounts, determined by applying the most recently adopted and effective Medicare Inpatient Prospective Payment System (IPPS) reimbursement formula and factors as published annually in the Federal Register. The following minimal modifications shall be applied.
   (1) The sum of the Medicare facility specific reimbursement amount and any applicable outlier payment amount shall be multiplied by:
   (A) 143 percent; unless
   (B) a facility or surgical implant provider requests separate reimbursement in accordance with subsection (g) of this section, in which case the facility specific reimbursement amount and any applicable outlier payment amount shall be multiplied by 108 percent."

   Review of the documentation finds that that the facility requested separate reimbursement for implantables; for

that reason, the requirements of subsection (g) apply.

4. §134.404(g) states, in pertinent part, that "(g) Implantables, when billed separately by the facility or a surgical implant provider in accordance with subsection (f)(1)(B) of this section, shall be reimbursed at the lesser of the manufacturer's invoice amount or the net amount (exclusive of rebates and discounts) plus 10 percent or $1,000 per billed item add-on, whichever is less, but not to exceed $2,000 in add-on's per admission.
   (1) A facility or surgical implant provider billing separately for an implantable shall include with the billing a certification that the amount billed represents the actual costs (net amount, exclusive of rebates and discounts) for the implantable. The certification shall include the following sentence: "I hereby certify under penalty of law that the following is the true and correct actual cost to the best of my knowledge."

Review of the documentation found supports that the following items were certified as required by (g):

Rev Code	Cost Invoice Description	# Units & Cost Per Unit	Cost Invoice Amount	***Per item*** Add-on (cost +10% or $1,000 whichever is less).
278	.5ml BioDfactor	3 @ $5,000.00	$15,000.00	$1,500.00
278	10cc Cancellous Chips 1-4 mm	3 @ $500.00	$1,500.00	$150.00
278	10 cc H-Genin Putty	3 @ $2,750.00	$8250.00	$825.00
278	10 cc Cancellous Chips 1-4 mm	3 @ $500.00	$1,500.00	$150.00
278	10 cc H-Genin Crush Mix	2 @ $2,750.00	$5,500.00	$550.00
278	AmnioFix Amniotic Membrane	1 @ $5,000.00	$5,000.00	$500.00
278	TLIF Peek Cage	1 @ $6,050.00	$6,050.00	$605.00
278	CapLox II Poly Axial Pedicle Screw	6 @ $2,800.00	$16,800.00	$1680.00
278	CapLox II Curved Rod	2 @ $650.00	$1,300.00	$130.00
278	CapLox II set screw	6 @ $350.00	$2,100.00	$210.00
278	Spondy Fixation Thoracolumbar Cross	1 @ $2650.00	$2,650.00	$265.00

$65,650.00	$67,650.00
Total Supported Cost	**Sum of Per-Item Add-on**

The division finds that the facility supported separate reimbursement for these implantables, and that the cost invoices were certified as required. Therefore, the MAR is calculated according to §134.404(f)(1)(B).

5. §134.404(f)(1)(B) establishes MAR by multiplying the most recently adopted and effective Medicare Inpatient Prospective Payment System (IPPS) reimbursement formula and factors (including outliers) by 108%, ***plus*** reimbursement for items appropriately certified under §134.404(g). The Medicare IPPS payment rates are found at http://www.cms.gov, and the sum of the per-item add-on for which separate reimbursement was requested are taken from the table above.

- Documentation found supports that the DRG assigned to the services in dispute is 460, and that the services were provided at First Surgical Hospital. Consideration of the DRG, location of the services, and bill-specific information results in a total Medicare facility specific allowable amount of $74,086.11. This amount multiplied by 108% results in an allowable of $141,736.11.
- The total cost for implantables is $65,650.00. The sum of the per-billed-item add-ons exceeds the $2000 allowed by rule; for that reason, the total allowable amount for implantables is $65,650.00 plus $2,000, which equals $67,650.00.

Therefore, the total allowable reimbursement for the services in dispute is $74,086.11 plus $67.650.00, which equals $141.736.11. The respondent issued payment in the amount of $23,612.20. The requestor is seeking

$65,650.00. This amount is recommended.

Conclusion

For the reasons stated above, the division finds that the requestor has established that additional reimbursement is due.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code Sections 413.031 and 413.019 (if applicable), the Division has determined that the requestor is entitled to additional reimbursement for the services involved in this dispute. The Division hereby ORDERS the respondent to remit to the requestor the amount of $65,650.00 plus applicable accrued interest per 28 Texas Administrative Code §134.130, due within 30 days of receipt of this Order.

Authorized Signature

Signature	Medical Fee Dispute Resolution Officer	August , 2014 Date
Signature	Medical Fee Dispute Resolution Manager	August , 2014 Date

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute has a right to seek review of this decision in accordance with 28 Texas Administrative Code §133.307, effective May 31, 2012, *37 Texas Register 3833*, **applicable to disputes filed on or after June 1, 2012**.

A party seeking review must submit a **Request to Schedule a Benefit Review Conference to Appeal a Medical Fee Dispute Decision** (form **DWC045M**) in accordance with the instructions on the form. The request must be received by the Division within **twenty** days of your receipt of this decision. The request may be faxed, mailed or personally delivered to the Division using the contact information listed on the form or to the field office handling the claim.

The party seeking review of the MDR decision shall deliver a copy of the request to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §141.1(d).

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.